Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXII, n. 1, 2021
doi:10.4081/rp.2021.352

Psychopathology in the Perinatal Period: Beyond Postpartum Depression

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ABSTRACT. – Having a child has always been perceived as something natural, something simply written in the journey of the life of any couple. However, natural is not a synonym for easy, nor ordinary, and the diverse possible medical and psychological complications are proof that bearing children is actually quite an extraordinary event. Similar to other life events, the birth of a child can be an experience that is accompanied by suffering, that does not always find the right support or adequate clinical answers. In the perinatal period serious psychopathology can exist and can be of varying degrees of severity. In the complexity of becoming a parent and within this we can find useful tools for the comprehension of psychopathology. Having a respectful outlook about these complexities means understanding signs and symptoms of distress that can be of differing intensity. As clinicians we must open ourselves up to the deeper meanings of suffering and be able to respond to medical and psychiatric priority needs. It is an ethical burden for anyone who approaches perinatal psychology to have the adequate knowledge to do so. Clinical and research attention of the perinatal period has in time focused almost exclusively on the mother's postpartum depression, creating an algorithm that has consolidated itself in time: perinatal psychopathology = postpartum depression, but this is reductionist and misleading. The objective of this article is to explore this paradigm and highlight the ordinary and extraordinary complexity that is inherent to 'becoming parents'.

Key words: Motherhood; fatherhood; parenting; psychopathology in the perinatal period; complex emotional experience.

Psychopathology in the perinatal period: the management of vulnerability and opportunity

For many years clinical and research attention in the field of psychopathology during the perinatal period has focused on what happens after

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birth, despite the incidence of psychopathology during pregnancy being analogous to that in postpartum. Expecting a child is still seen only as an experience of unconditional happiness in which a woman is 'hormonally protected' (Bennett, Einarson, Taddio, Koren, & Einarson, 2004). This cultural image has led to the underestimation of psychological vulnerability during pregnancy. While it is much more well-accepted that a woman can have physical discomforts, these however can hide her distress. There are many confounding factors: vomit, fatigue, sleepiness, anhedonia, anergia, tension and irritability, which are somatic symptoms generally associated with pregnancy (Howard, Piot, & Stein, 2014), make it difficult to identify underlying anxiety and depressive disorders (Lee *et al.,* 2007). Disregarding the somatopsychic unity of a woman as an individuum (Adler, 1956) - who cannot be divided into 'components' such as those conventionally used: physical and psychological - one runs the risk of overestimating the psychological origin of somatic disorders (Yonkers, Smith, Gotman, & Belanger, 2009) or, on the other hand, of underestimating it and attributing these disorders exclusively to those that are part of the normal pregnancy process (Klein & Essex, 1994).

By examining the data, the incidence of maternal depression changes depending on the period that is being observed: during pregnancy it varies between 14% and 23% of pregnant women, in the time immediately postpartum so within the first 72 hours it is 11%, while it is around 17% in the first 3 months of life after birth. The incidence of depression is around 30% if we consider up to a year's time after the birth (Cox, Sowa, Meltzer-Brody, & Gaynes, 2016).

The results of an American study show that 33% of postpartum depression starts during pregnancy and 27% before it. Furthermore, evidence suggests that there could be a prevalence of major depressive disorder symptoms during pregnancy compared to the postpartum period (Howard, Molyneaux, *et al*., 2014).

It is therefore important to broaden our attention beyond the postpartum period because pregnancy seems to be a period of extreme vulnerability. Underestimating pregnancy as a period of vulnerability is a shortcoming that has just as many implications for the mother and father, as it does for the child/future adult (Biaggi*,* Conroy, Pawlby, & Pariante, 2016).

It is now widely recognised that depression, anxiety and stress during pregnancy have significant long-term consequences on the mother and her child (Dunkel Schetter & Tanner, 2012; Glover, 2015) and that the emotional state of the mother has an influence on the foetus that is developing (Lautarescu, Craig, & Glover, 2019).

For the mother the presence of an anxiety disorder or mood disorder during gestation is in fact included among the principal risk factors for developing postpartum depression (Biaggi *et al*., 2016). Moreover, the presence of

psychopathology during pregnancy is correlated to an increased risk of abusing alcohol and drugs, smoking, engaging in risky behaviours and malnutrition (Marcus, 2009; Biaggi *et al*., 2016). Various studies report that mothers affected by anxiety or mood disorders have neglectful behaviours with regard to the pregnancy, such as a late access to health services, gynaecological appointments and ultrasound check-ups (Biaggi *et al*., 2016). High levels of stress and psychopathologies are correlated with an increased risk of pre-eclampsia and maternal hypertension (Biaggi *et al*., 2016; Stein *et al.*, 2014).

In addition, but no less important, the presence of psychopathologies can negatively influence the mother's self-perception, her expectations on her maternal experience and the delicate construction of the mother-child bond (Hipwell, Goossens, Melhuish, & Kumar, 2000).

For the new-born and future child, the emotional state of the mother and, more generally, high stress levels, can have consequences on a short-, medium- and long-term (Glover & Capron, 2017; Lautarescu *et al.,* 2019). Prospective, retrospective and longitudinal studies demonstrate this both in animal models and human cohorts, via genetic and biological indicators (Molenaara *et al.*, 2019; Hannigan *et al*., 2018).

The interaction between a mother (environment) and foetus is complex and dynamic, and to this day is still being investigated, however, some possible mechanisms through which psychopathology and maternal stress can impact foetal development have already been analysed.

It is important to underline that no one condition, even the most unfavourable, can be conceived as an inevitable destiny; when we consider the possible consequences we are observing the result of a complex and extraordinary interaction between genetics, environment, risk factors, protection factors, mediator factors and an individual's ability for neuroplasticity, for recovery and repair.

Exposure to stress and psychopathology in the prenatal period are associated with neurobehavioral alterations that can persist from birth up until late adolescence (Stein *et al.*, 2014), with consequences that range from cardiovascular problems (Stirrat *et al.,* 2018) to psychiatric ones (Krontira, Cruceanu, & Binder, 2020). More specifically, among the main possible short-term consequences we can list the following: premature birth, low weight at birth, smaller head circumference (Biaggi *et al*., 2016; Stein *et al.*, 2014); in the medium- to long-term: anxiety, depression and stress during the prenatal period are associated with a higher risk of emotional problems (anxiety and depression in particular), cognitive development disorders and ADHD symptoms (Biaggi *et al*., 2016; Glover, 2014; Stein *et al.*, 2014).

These risks, however, are not inevitable (Stein *et al.*, 2014). Regarding the potential consequences of stress and psychopathology in a perinatal period, it has been widely demonstrated that certain so-called mediator or moderating factors have an effect, such as: the presence of social support, socio-economic

status, the severity and duration of the stress or of the psychopathological disorder, the presence of a partner, the absence of conflict within the couple, the family atmosphere and the quality of parenting (Stein *et al.*, 2014).

The pregnancy period is a real temporal window of opportunity where it is possible to act in a preventative sense with immediate positive and future effects. Giving value to gestation means increasing the possibility of dealing with vulnerability and its possible consequences. It is the time in which we must try to seize the opportunity to meet with the future mother and the couple - much more so than in the postpartum period - and these meetings can be a concrete opportunity of prevention and early intervention.

Psychopathology in the perinatal period: postpartum depression and more

Psychological suffering in the perinatal period can present itself in different ways, from distress to a genuine psychopathology, up to conditions of medical emergency. In all these manifestations one must accommodate them adequately in a clinical setting.

Pregnancy and the birth of a child, disruptions in a woman's existential experience, can bring with them a potential for change and vulnerability, which for some mothers and fathers constitutes a risk in and of itself for developing or re-exacerbating (if already present), true forms of psychopathology.

For decades we have focalized on postpartum depression as the only psychopathological manifestation linked to the perinatal period, but in reality, the entire range of nosographically distinct disorders can become exacerbated if they are already present in one's personal history or can manifest for the first time, *new onset* (Smith *et al*., 2011). The acronym PMAD, *Perinatal Mood and Anxiety Disorder,* establishes an important recognition of this in the scientific and clinical fields, as within the PMAD 'category' the spectrum of depressive, anxiety, obsessive compulsive, post-traumatic stress disorders as well as postpartum psychosis are included (Byrness, 2018).

It is beyond the scope of this article to describe the different forms of psychopathology; I will limit myself to emphasizing that it is nonetheless necessary to contextualize them with all their peculiarities in this specific period of life for an adequate comprehension of their manifestation.

Postpartum depression remains the only disorder of the perinatal period recognized by the DSM starting from the IV edition; comparing the diagnostic criteria within this edition for a depressive disorder, the only peculiarity linked to postpartum depression is to consider this period as the onset. It is only in the last edition that it has been expanded to the time during pregnancy and up to 6 months postpartum (before it was 4 months)

and the concept *peripartum onset* has been introduced (American Psychiatric Association [APA], 2016; www.postpartum.net). The peak incidence of postpartum depression has been estimated as being during the fifth and ninth month after the birth of a child, but there are numerous indications that, in the face of clinical evidence, clinicians should be urged to consider the entire first year postpartum (APA, 2016; www.postpartum.net).

Although it has not been made explicit, PPD (postpartum depression) often exhibits comorbidity with other disorders such as generalized anxiety disorder, specific phobias, obsessive-compulsive disorder, PTSD and personality disorders (Howard, Molyneaux, *et al*., 2014). Additionally, often the depression is secondary to the presence of for instance an anxiety disorder, but the lack of recognition of the latter in clinical and research settings endorses the underestimation of disorders that are not depressive ones (Ali, 2020).

Over time a distinction between *maternity blues*, postpartum depression and postpartum psychosis has been consolidated: this classification certainly conveys the idea of different nuances of severity but can be misleading as it ignores the event of pregnancy and reduces everything to the mood disorder spectrum.

Maternity blues is very frequent, estimated to affect around 50% (Ali, 2020) or 40%-80% of women who have recently given birth (www.nichd.nih.gov/health/publication/postpartum-depression-facts/index.shtml) and seems to be mainly associated with the sharp drop in oestroprogestinic hormones after delivery. It manifests with emotional lability, crying easily, tension, restlessness and feelings of inadequacy. It presents in the first few days after birth and tends to resolve spontaneously in a few days (Ali, 2020). *Maternity blues* can be considered an alarm bell: for women who develop maternity blues 20% can go on to develop postpartum depression (Kennerley & Gath, 1989). Postpartum psychosis is considered the most severe condition of all, it represents 1-2 cases per 1000 births and should be considered a real emergency that needs immediate medical intervention (Jones, Chandra, Dazzan, & Howard, 2014).

As perinatal psychologists we must make sure that women feel as best they can, we must be aware that the job of a psychotherapist takes time and that certain conditions cannot and must not wait. The work of a psychotherapist is not mutually exclusive in terms of the need for psychiatric intervention: multidisciplinary discussion and collaboration are fundamental.

Acknowledging the existence of severe psychopathologies even during the perinatal period does not mean pathologizing the experience of maternity but rather safeguarding it. On the other hand, suffering must not be simplified or normalized. The physiological disorientation, the maladjustment,

the different manifestations of psychological distress and the frank forms of psychopathology of both the mother and father, can find a key for comprehension and treatment in the complexity of becoming parents, as the conclusive paragraph of this paper will try to illustrate.

The psychopathological manifestations in the perinatal period have a multifactorial origin and they arise from a complex interaction of different risk factors: genetic, biological, and environmental, that can assume meaning that is tied to the subject, to the 'use' that the subject makes of them, and the specific moment of interaction and the persistence of its presence (Petrilli, Anniverno, Ferrari, & Mencacci, 2010; Stein *et al.*, 2014; Biaggi *et al*., 2016).

Scientific literature registers the following among its principal risk factors (*versus* protection factors) for developing psychopathologies in the perinatal period: positive anamnesis for previous psychopathologies, a family history of psychiatric disorders, previous postpartum depression, a family history of postpartum depression, anxiety during pregnancy, low socio-economic status, hormonal vulnerability, an unexpected or unwanted pregnancy, absence of social support, absence of a partner or an unsupportive partner, pregnancy complications, labour complications or new-born complications, premature birth, stressful events during pregnancy, interpersonal violence, and dysfunctional personality traits (Biaggi *et al*., 2016; Byrness, 2018).

An accurate analysis of risk factors is useful for the comprehension of the distress condition but also for the choice of treatment course. Not only this, but every risk factor also constitutes a possible focus for prevention.

For example, as clinicians, knowing that the presence of anxiety during pregnancy is a risk factor for the development of postpartum disorders means informing the couple and urging them to examine these anxious symptoms in depth during pregnancy; or, knowing that 20% of maternity blues cases can evolve into postpartum depression is a useful datum for clinicians who can look out for this during the patients' stay in hospital and decide to monitor them in time; or, for the couple who will become future parents, being aware of these issues is useful and they may keep an eye out for them and take action if they deem it necessary. All of this is only possible if we give them the correct information and, prior to this, that clinicians who work in the 'world of birth' are opportunely educated.

A possible prevention and sensitization activity is that of informing the couple about the possible risk factors and protection factors. This means giving them an active role in their experience as parents, putting the knowledge into their hands - doing so in an adequate manner and by people who have the competences - so that they can become protagonists of their own well-being and quality of their experience as parents. There remains still much to do in this direction, and we seem to still be far from putting this

approach into action fully, but perhaps the growing interest for perinatal psychology will help to bridge the gap.

Psychopathology in the perinatal period: the partner, the father

The discussion of this topic in this article is not exhaustive and it deserves a more in-depth analysis on its own, however, it is appropriate and in line with the aim of this article, to explore this topic, even if just briefly.

The exclusive prospective of mother-child, which has always dominated the field, should be challenged. The recognition of the role of the father and his mental health are becoming progressively more important in the perinatal period (Stein *et al.*, 2014), but it has in reality been neglected for a long time and has always taken a backseat.

In 1975 Michael E. Lamb's '*Fathers: forgotten contributor to child development*' (Lamb, 1975), which in itself is an explicative title, asserted how, although the father was often forgotten, he had a direct and independent influence on the child from the mother, both in the postpartum period and during pregnancy. The children whose fathers were involved during pregnancy and who were also present during labour (in times in which this was not the common practice), had more positive outcomes during development (Lamb, 1975). Following this, many other longitudinal studies confirmed these results.

The father and his mental health can influence the child directly through the quality of his interaction, via his genetic heritage, and even indirectly through his support of the mother and the contribution to the family environment (Stein *et al.*, 2014). Further, albeit through different mechanisms, the lack of emotional availability of the father, his absence or death can have negative effects on the emotional, cognitive and behavioural development of his children (Glover & Capron, 2017). The mental health of the father has an influence on the development of the child, even during pregnancy (Sweeney & McBeth, 2016). They found that the relationship between the behaviour of the father, the quality of his presence, his mental health and the short-, medium- and long-term consequences is not direct but rather is mediated by the relationship with the mother (Sweeney & McBeth, 2016). The father, together with his ability to be emotionally and practically supportive, is among the more incisive protection and mediator factors in the presence of maternal psychopathology, reducing its extent and impact (Stein *et al.*, 2014).

In the face of this evidence, which shows how much the father is influential, even during pregnancy, the mother cannot be thought of as 100% of the environment of the child that she carries in her womb, because the 'relational environment' (that is, the partner in relationship with the mother and

the baby) seems to prevail: mother and father, as a couple. The mother and father (the couple) together constitute 100% of the environment in which the child is brought up in and the child in turn interacts straight away actively with this environment: from a couple to a triad, becoming a 'we'.

Except for the hormonal upheaval, even the father is subject to the same turmoil as the mother, and even for him the adaptation to a new equilibrium can happen with difficulties that can manifest starting from slight maladjustment up until manifestations of true psychopathology.

The percentage of paternal depression in the perinatal period is only slightly lower than that of mothers, estimated at approximately 11-12% during pregnancy and 8% to 26% in the postpartum period, with an overall of 9% during the perinatal period (Cameron, Sedov, & Tomfohr-Madsen, 2016).

Paternal affective disorders tend to manifest in a different way compared to women and, although they are frequent, they are often underestimated or undiagnosed, as well as overlooked by research (Baldoni, 2016; Baldoni & Giannotti, 2017). There are cultural biases, such as the phrase 'males don't cry', and other significant confounding factors: emotional problems and depression manifest differently in men, in 'typically masculine' ways, that is, with aggression, alcohol abuse and withdrawal. There are also social stereotypes which dictate that fathers are not involved as much in parenting and this creates a 'mum-centric' culture for future parents (Baldoni, 2016; Baldoni & Giannotti, 2017) which gives rise to an exclusion experience in men.

It is difficult to separate the father and his 'being there', because he is part of the whole where complex dynamics are activated. Having a child is often (but not always, such as in the choice of being a single parent) a couple matter, that is, of two subjects, with their individual and couple motivations, expectations and investments in a particular moment in time during their lives. Having a child is a choice - with access to abortion during pregnancy and medical innovations in the field of infertility - which asks the co-protagonists to open themselves up and open themselves up to the other in the couple as well. In the triad there is the child - that child with particular physical and temperamental characteristics - and his/her way of interacting with the mother and father in a reciprocal way that begins even before the birth of the child. The child is dreamt of and anticipated and he or she exists and interacts with the mother and father even before he or she is conceived.

Psychopathology in the perinatal period: concluding considerations

The need to expand the outlook of couples so as to give their child the correct identity is evident. Opening up to the triad that is to come means giving due weight to the woman who will only benefit from this openness,

especially when she is suffering: but focalizing research only on the suffering of the mother is misleading and reductionist (Merisio, 2017). In the face of a woman who is suffering there seems to be only her, and if this aspect is not considered the individual work with the mother risks becoming a setting in which we collude to maternal exclusivity, that does nothing but foster the suffering of the mother herself, creating distance within the couple and separating the mother, father and child.

Even psychopathology represents the 'best' response that the subject takes to confront the innate upheaval of becoming a parent, a response that is not 'exclusively attributable to the intrapsychic world of the woman' (Merisio, 2017, p. 46), nor directly ascribable to her genetic heritage, nor her hormonal make-up, let alone the environment that surrounds her. Rather it has a multifactorial and subjective origin 'it is the system in itself that drives life and it does so always in function of what she can withstand and manage' (Minolli, 2009, p. 103). Becoming parents brings with it the demands of numerous challenges, from this a situation of natural complexity originates.

The couple is asked to 'move from a level of previously obtained consistency, to the construction - neither magic nor omnipotent- of a new level of coherence' (Minolli, 2009, p. 102) and this transition is complex by nature, it can be painful, it can disorient, it can create maladjustments or reach a form of true psychopathology.

So, what causes the mother or father to find themselves in a condition of distress or psychopathology? A subjective interaction, which is unique in individuals who have their own sense of experience of maternity and paternity, with risk and protection factors that they themselves bring and that they find in their environment. An interaction from which the impact of change originates, that generates pathological or physiological crises.

However, change is not the only aspect implicated, below the main are explored. Even the body of a woman faces a strong experience. First of all, it is modified and for some women it deforms according to how they live this change. Subsequently, with labour it is disregarded in virtue of other priorities and this can leave both physical and psychological wounds. Body image and its identity valence are called on and strained. The body also becomes an exceptional container that flourishes and that for some women is difficult to separate from this source of fullness and well-being. All of this does not only occur on a physical level.

Giving birth to a child is in itself a complex emotional experience: from the initial idea of wanting to have a child up to its birth and beyond, the mother and father can find themselves in difficulty for the compresence of emotional states that are apparently contrasting between themselves and can generate anxiety.

Emotional ambivalence is often denied and silenced because it scares

parents or because 'you can't say certain things' or because they fear judgment because they do not feel like they are good parents or parent enough. However, what they do not recognize within themselves or that they do not express can sometimes end up in silent suffering, in depression or in the worst of despairs, which in turn foments feelings of guilt that cannot be spoken of and that can take on exaggerated forms (Galimberti, 2009). We can give voice to the taboos and we can open up to the possibility of not only experiencing joy, it does not mean not being happy or not being able to find happiness. Experiencing fear, anger and sadness does not mean you are less of a parent nor less good at it, but some mothers and fathers cannot say it to each other: the ambivalence is part of the experience of maternity and paternity. Opening ourselves up to this possibility without rejecting it or judging it is the way forward.

Becoming parents is an experience that requires openness and flexibility. It is often the case that people who are inclined towards rigidity and closure, which often go hand in hand with perfectionism and self-criticism and criticism towards others, find themselves in a lot of difficulty in pregnancy and in the postpartum period. This can be due to the fact that no experience more than this one puts you in contact with unpredictability and with the absence of control. This is true starting from when a woman becomes pregnant which usually happens in an unexpected way, even though the couple may have been trying for a child, or too late, when the couple were no longer hoping to have one. The uncertainty tied to when the mother will go into labour, or rather, when the child decides to be born can destabilize further. Moreover, what will the child be like? How will breastfeeding go? How and will I be able to do it? A lot of questions that need to tolerate waiting for an answer.

Change, when one realizes it, disorients subjects that have implemented it, despite the fact it may have been desired. However, we do not talk of this and for this reason, a couple may find themselves lost in front of what they so desired and they may experience anxiety or distress.

Furthermore, for many parents this change must have pre-established characteristics and high expectations, which are sometimes impossible to fulfil. Mother and father often defend themselves against the fear of not having control by sometimes constructing expectations. Furthermore, the incessant search for certitudes within an experience that is by nature uncertain brings about various possible manifestations of distress and symptoms that represent the inevitable encounter with reality. Preparing to be open and flexible is beneficial and the pregnancy period is a good moment to do so. Even in this sense, having a child is a mournful experience. The couple may mourn the 'ideal'. The ideal of control, the ideal of the self, of the postpartum, of their partner and of the imagined child. One can narrow the gap between ideal and real only through experiencing it. In this way the painful loss of conviction is realized and 'all will go back to how it was before', this

pretence/illusion is useful and is often constructed and maintained during pregnancy because it helps to live the change as 'less of a change', as less frightening. The mourning is experienced as a 'myth of maternal love' (Galimberti, 2009) when a mother feels undesired emotions or unexpected ones towards her child and towards her project of becoming a parent. Lastly, it is the mourning of omnipotence, of the 'everything is possible': this belief is present before when the child is only desired and then is present in the womb, everything really seems possible at this tstage. However, then one gains awareness of one's impotence, which is the most authentic innate experience of maternity and paternity and it is not infrequent that the difficulty of acceptance of impotence is the basis of suffering that the mother and father can find themselves experiencing.

In the complexity of the maternal and paternal experience there is also the encounter with someone who is different from the self. That other is the partner and the other is the child, both with characteristics that might not correspond with one's expectations, thus it is a love that occupies us in the task at hand, for some it is very difficult and painful, in the development of a social sentiment and in the acceptance of the other for what they really are. 'The other' is also that side of ourselves that we discover only in the moment in which we have a particular experience and that we learn to understand if we are willing, in time. Many men and women, in living as mothers or fathers, surprisingly discover certain skills and resources that they did not know they had; in this sense having a child is an eye-opening experience.

Becoming parents is an evolutionary experience that brings with it pains that we could define as growing pains, unique to this difficulty in moving from child to parent and no longer being just a son or daughter.

Having a child also means experiencing first-hand that wanting a child is different from having a child (Florita, 2021) and that being parents does not automatically mean that you recognise yourself as one.

The experience of parenting is an existential experience because it touches on existential themes like that of choice, of the irreversibility of choice and the definition of the self in that choice, the theme of liberty, responsibility and the search for meaning (Yalom, 1980) and related to this, how difficult is it to find meaning in the choice of having a child that it can unexpectedly cause suffering? How difficult is it to be responsible? How easy is it to delegate outside of oneself this choice and this suffering? How much easier is it to define oneself as an ideal, except for when we feel completely lost, when that ideal and reality do not correspond? In the effort and suffering we lose sight of the fact that it was a choice, an active one, and this aspect must be recovered, conversely the suffering cannot do anything but self-sustain itself and be experienced as something that 'comes from outside' on which we cannot enter and that we can only endure, but this is misleading and involutional.

In the choice of having a child, more than in others, various fundamental aspirations of man intersect self-actualisation, the *will to power*, the *social sentiment*, the love for others, cooperation and emotional sharing (Adler, 1956). An imbalance between these can betray narcissistic investments or be an index of maladjustment or psychopathology, while their balance is a barometer of mental health (Adler, 1956).

Having a child also touches on the theme of death, in the visceral relationship between life and death, it takes us nearer to death experiences and touches our sense of mortality and, in doing so, we prolong our own existence and partially realize our desire for immortality (Yalom, 1980; Minolli & Coin, 2007).

Last but not least, having a child is a social experience.

We sometimes forget that having a child is giving society a gift, but we cannot omit that the couple is immersed in the society in which it lives and creates in that particular moment in time, in that space, and not in others. How much does society facilitate this defining of oneself? How much does it help in the realization of this desire? How much does it contribute to the isolation of the couple that generates this distress? How much does this suffering find a welcome place? Only in the last few years has the healthcare and territorial setting implemented structured screening and prevention interventions, but there is still much to do in order to build a culture of psychological wellbeing during pregnancy and in the postpartum, in order to uproot certain cultural stereotypes, which are for instance more limiting than the absence of services or dedicated political welfare. Moreover, the changing couple does not recognize itself in a before of becoming parents, but not even in a historical time before. Now, more than ever, we do not have great role models and often those that we have, we criticize, they do not help us, as though we were without a navigation system or a map. The mother was once seen as the figure who was exclusively dedicated and devoted to taking care of the child, and was busy 'not giving the child bad habits', reinforcing cultural stereotypes at the expense of needs for tenderness that are innate to human nature and for maternal and paternal intuition (Bortolotti, 2010); in the past the mother had a need to defend herself from the child's tyranny over the time she had during a day, and this attitude, which we still feel echoed today, made sense for the woman who needed to be protected from something that would have suffocated or engulfed her. Today perhaps we have to re-examine the dimension of sacrifice, that has long been one of the only ways of seeing one's choice for maternity and paternity and of living parenthood. The father is not a function nor a role, but a protagonist, just like the mother, of an experience that can express itself in 'innovative choices' that turn the historical characteristics of the father upside down. Likewise, information from the 24th of June 2020 from ANSA makes us reflect: in the year 2019 32,000 first time mothers left

work, this makes up 73% of all people who resigned from work that year. How much will society allow mother and father to be aligned in their parental roles in practice?

The therapist who wishes to work in this field opens himself/herself up to a very hard, gratifying and interesting job, where great attention must be given to therapist's own experiences and meanings as parent and child.

It is fascinating to accompany a couple in the realization of their project and see life being born through moments of fear and pain. Helping the couple in the loss that is change and the generational mutations without giving them a map, but by cultivating together with the couple a trust in the their own creativity and ability so that they can create their own is one of the tasks of a perinatal psychologist.

Reharmonizing the couple on their own protagonism in their desire for change, bringing them back to the naturalness (a term that is erroneously used in the same manner as easy or automatic) of the birthing event before anything else – except for extreme conditions such as unwanted pregnancies or pregnancies that resulted from violence – as a gift, a fruit of love, of passion, vitality and planning.

The opportunity that pregnancy offers goes beyond being a temporal window in which one can intervene preventatively or precociously, because becoming a parent is a push towards ourselves that imposes a new understanding of the self that needs a new vital balance (Merisio, 2017; Minolli & Coin, 2007). If this opportunity is seized, even in its most painful expressions, it has an enormous transformative and evolutionary power. Even in the psychopathological manifestations there are drives towards planning, vital desires that disguise themselves in suffering, to the eyes of most, hiding profound meanings that can be explored and often want to be unearthed.

The task of the therapist is to create a sense of space where we can welcome and observe these most profound meanings, in order to reach a clearer line of vision together, a line of vision that is respectful of all the complexities and make space for a possible new perspective.

Acknowledgements

A heartfelt thanks to Dr. Emi Bondi, director of Mental Health Department and primary of the Psychiatry Unit- ASST Papa Giovanni XXIII Bergamo, Italy, whose sensitivity has given birth to an outpatient service dedicated to the care of mental health in the perinatal period. Heartfelt thanks to all the parents and their children met in recent years at the Varenna outpatient service- Psychiatry Unit-ASST Papa Giovanni XXIII Bergamo, Italy.

I would like to thank my esteemed colleagues from the Perinatal

Department SIPRe-Milano. Special thanks to Claudia Maspero and Valeria Pirro. Thank you to Marcello Florita and SIPRe-Milano for their warm welcome. I would also like to extend my endless gratitude to Romina Coin for her contribution to my personal and professional growth. Thank you to Carmine, Giulia and Ginevra, my family.

REFERENCES

Adler, A. (1956). *The individual psychology of Alfred Adler*. New York: Basic Books, Inc. [Transl. Ansbacher H.L., & Ansbacher R.R. (1997). *La psicologia individuale di Alfred Adler, Psycho*. Firenze. G. Martinelli and C.].

Ali, E. (2020). Women's experiences with postpartum anxiety disorders: a narrative literature review. *International Journal of Women's Health, 10*, 237-249. doi:10.2147/IJWH.S158621.

American Psychiatric Association (APA). (2016). *Manuale diagnostico e statistico dei disturbi mentali - 5th ed. (DSM-5)*. Milano: Raffaello Cortina Editore.

Baldoni, F. (2016). I disturbi affettivi perinatali nei padri. In P. Grossu & A. Bramante (Eds.), *Manuale di psicopatologia perinatale* (pp. 443-485). Milano: Erickson.

Baldoni, F., & Giannotti, M. (2017). I disturbi affettivi perinatali paterni: valutazione, prevenzione e trattamento. In A. Imbasciati & L. Cena (Eds.), *Psicologia clinica perinatale. Neuroscienze e psicoanalisi* (pp. 218-239). Milano: Franco Angeli.

Bennett, H.A, Einarson, A., Taddio, A., Koren, G., & Einarson, T.R. (2004). Prevalence of depression during pregnancy: systematic review. *Obstetric Gynecology, 103*(4), 698-709. doi:10.1097/01.AOG.0000116689.75396.5f

Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C.M. (2016). Identifying the women at risk of antenatal anxiety and depression: a systematic review. *Journal of Affective Disorder, 191*, 62-77. doi:10.1016/j.jad.2015.11.014

Byrness, L. (2018). Perinatal mood and anxiety disorder. *The Journal of Nurse Pratictioners, 14*(7), 507-513. doi:10.1016/j.nurpra.2018.03.010

Bortolotti, A. (2010). *E se poi prende il vizio. Pregiudizi culturali e bisogni irrinunciabile dei nostri bambini.* Torino: Il Leone Verde.

Cameron, E.E., Sedov, I.D., & Tomfohr-Madsen, L.M. (2016). Prevalence of paternal depression in pregnancy and the postpartum: an updated meta-analysis. *Journal of Affective Disorder, 206*, 189-203. doi:10.1016/j.jad.2016.07.044.

Cox, E.Q., Sowa, N.A., Meltzer-Brody, S.E., & Gaynes, B.N. (2016). The perinatal depression treatment cascade: baby steps toward improving outcomes. *Journal of Clinical Psychiatry, 77*(9), 1189-1200. doi:10.4088/JCP.15r10174.

Florita, M. (2021). One Cannot Touch Without Being Touched: Why Psychoanalysis Needs to Draw from the Perinatal, and *Vice Versa*. *Ricerca Psicoanalitica, 32*(1), 9-23.

Galimberti, U. (2009). *I miti del nostro tempo*. Milano: Feltrinelli.

Glover, V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best practice & research. Clinical obstetrics & gynaecology, 28*(1), 25-35. doi:10.1016/j.bpobgyn.2013.08.017.

Glover, V. (2015) Prenatal stress and its effects on the fetus and the child: possible underlying biological mechanisms. In M. Antonelli (Ed.), *Perinatal programming of neurodevelopment. advances in neurobiology*, *vol. 10* (pp. 269-283). New York, NY: Springer.

Glover, V., & Capron, L. (2017). Prenatal parenting. *Current Opinion in Psychology, 15*, 66-70. doi:10.1016/j.copsyc.2017.02.007.

Dunkel Schetter, C., & Tanner, L. (2012) Anxiety, depression and stress in pregnancy:implications for mothers, children, research, and practice. *Current Opinion in Psychiatry,* 25(2), 141-148. doi:10.1097/YCO.0b013e3283503680.

Hannigan, L.J., Eilertsen, E.M., Gjerde, L.C, Reichborn-Kjennerud, T., Eley, T.C., Rijsdijk, F.V., Ystrom, E., & McAdams, T.A. (2018). Maternal prenatal depressive symptoms and risk for early-life psychopathology in offspring: genetic analyses in the Norwegian Mother and Child Birth Cohort Study. *Lancet Psychiatry, 5*(10), 808-15, doi:10.1016/S22150366(18)30225-6.

Hipwell, A., Goossens, F., Melhuish, E., & Kumar, R. (2000). Severe maternal psychopathology and infant-mother attachment. *Development and Psychopathology, 12*(2), 157-175. doi:10.1017/S0954579400002030,

Howard, L.M., Piot, P., & Stein, A. (2014). No health without perinatal mental health. *The Lancet*, *384*(9956), 1723-1724. doi:10.1016/S0140-6736(14)62040-7.

Howard, L.M, Molyneaux, E., Dennis, C.-L., Rochat, T. Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet, 384*(9956), 1775-88. doi:10.1016/S0140-6736(14)61276-9.

Jones, I., Chandra, P.S., Dazzan, P., & Howard, L.M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *The Lancet, 384*(9956), 1789-9910. doi:1016/S0140-6736(14)61278-2.

Kennerley, H., & Gath, D. (1989). Maternity blues. I. Detection and measurement by questionnaire, *British Journal of Psychiatry, 155*, 356-62. doi:10.1192/bjp.155.3.356.

Klein, M.H., & Essex, M.J. (1994). Pregnant or depressed? The effect of overlap between symptoms of depression and somatic complaints of pregnancy on rates of major depression in the second trimester. *Depression, 2*(6), 308-314. doi:10.1002/depr.3050020606.

Krontira, A.C., Cruceanu, C., & Binder, E.B. (2020). Glucocorticoids as mediators of adverse outcome of prenatal stress. *Trends in Neurosciences, 43*(6), 394-405. doi:10.1016/j.tins.2020.03.008.

Lamb, M. (1975). Fathers: forgotten contributors to child development. *Human Development, 18*(4), 245-66. doi:10.1159/000271493.

Lautarescu, A, Craig, M.C., & Glover, V. (2019). Prenatal stress: effects on fetal and child brain development. *International Review of Neurobiology, 150*, 17-40. doi:10.1016/bs.irn.2019.11.002.

Lee, A.M., Lam, S.K., Sze Mun Lau, S.M., Chong, C.S., Chui, H.W., & Fong, D.Y. (2007) Prevalence, course, and risk factors for antenatal anxiety and depression. *Obstetric Gynecology 110*, 1102-1112. doi:1097/01.AOG.0000287065.59491.70.

Merisio, A. (2017). *Depressione postpartum. Una questione di famiglia*. Roma: Alpes Italia Editore.

Minolli, M., & Coin R. (2007). *Amarsi amando*. Roma: Borla.

Minolli, M. (2009). *Psicoanalisi della relazione*. Milano: FrancoAngeli.

Molenaara, N.M., Tiemeierb, H., van Rossumd, E.F.C., Hillegersb, M.H.J, Bocktinge, C.L.H., Hoogendijka, W.J.G., van den Akkerf, E.L., Lambregtse-van den Berga, M.P., & El Marrounb, H. (2019). Prenatal maternal psychopathology and stress and offspring HPA axis function at 6 years. *Psychoneuroendocrinology, 99*, 120-127. doi:10.1016/j.psyneuen.2018.09.003.

Petrilli, G., Anniverno, R., Ferrari, V., & Mencacci, C. (2010). Stress e ansia in gravidanza: conseguenze e implicazioni. *Facts, News & Views, 10*(1), Feb. 2010.

Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M., & Pariante, C.M. (2014). Effects of perinatal mental disorders on the fetus and child. *The Lancet, 384*(9956), 1800-1819. doi:10.1016/S0140-6736(14)61277-0.

Stirrat, L.I., Sengers, B.G., Norman, J.E., Homer, N.Z.M., Andrew, R., Rohan, M. Lewis,

R.M., & Reynolds, R.M. (2018). Transfer and metabolism of cortisol by the isolated perfused human placenta. *The Journal of Clinical Endocrinology & Metabolism, 103*(2), 640-648. doi:10.1210/jc.2017-02140.

Sweeney, S., & McBeth, A. (2016). The effects of paternal depression on child and adolescent outcomes: a systematic review. *Journal of Affective Disorder, 205*, 44-59. doi:10.1016/j.jad.2016.05.073.

Yalom, I. (1980). *Existential psychotherapy - First Edition*. New York, NY: Basic Books. [Transl. S. Prina. (2019). *Psicoterapia esistenziale*. Vicenza: Neri Pozza Editore].

Yonkers, K., Smith, M.V., Gotman, N., & Belanger, K. (2009). Typical somatic symptoms of pregnancy and their impact on a diagnosis of major depressive disorder. *General Hospital Psychiatry, 31*, 327-333. doi:10.1016/j.genhosppsych.2009.03.005.

www.nichd.nih.gov/health/publication/postpartum-depression-facts/index.shtml

Conflict of interests: the author declares no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received for publication: 23 September 2020.
Accepted for publication: 13 December 2020.

Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2021; XXXII:352
doi:10.4081/rp.2021.352